Gambling Treatment in Norway

Innovation, Health Services and the Voluntary sector

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Abstract

The purpose of this paper is to examine innovation in voluntary organisations in Norway. Voluntary organisations can be key players in the future society with the increased pressure on the public sector, making public sector more dependent on other actors to deliver public services on their behalf. Voluntary organisations may not only deliver public services, but also create new solutions and third sector organisations are thought to be more flexible and capable to innovate.

This research is a case study of Blå Kors, a renowned voluntary organisation in Norway, and the development of a treatment service for gambling addiction in the early 2000s. The paper seeks to examine what challenges and opportunities were involved in the development of the innovation and how this coincides with international literature on the field of innovation and voluntary organisations. The case study set out to see what form of relationships or networks between public and third sector actors surrounded the innovation process, and the organisational environment internally in the organisation at the time.

Acknowledgements

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1 Introduction

Most of the innovation literature concerns the private sector and to some degree the public sector. A more neglected part of society is the volunteer/ non-profit sector, also known as the third-sector.

In innovation studies, the necessity of innovation is connected to continued economic growth. A non-profit organisation is by principle not interested in the possibilities of increased profit, but does this discourage innovation? This leads us to ask: What drives innovation in non-profit organisations?

A recent trend in innovation literature and in discussions on public policy has favoured a vision of social innovation as a solution to future societal problems, by encouraging an increased focus on innovative solutions developed by individual members of society. The public sector alone is not believed to be able to fix all problems in society, and this necessitates cooperation across sectors in order to discover and create future solutions. Social innovation can be seen as a trend shift towards the focus on society as a whole, encouraging all actors in society to contribute to a common improvement that will benefit everyone in some way. Social innovation is a hot topic in both the public and private sector in Norway. Innovation Norway addressed the topic and held a debate in the spring of 2015 to discuss how to solve future problems in Norway by thinking differently, with emphasis on social innovation. Representatives from the public, private, and third sector were attending the seminar (Innovasjon Norge, 2015).

A sector that has provided alternatives or contributed with solutions to the public sector is the third sector, and non-profit organisations can perhaps be key players in the future of social innovation. I have personal experience with work as a volunteer for different non-profit organisations both at a service level and on an administrative level, so the field of study has interested me for quite a while. The third-sector in Norway has played an important role through history by providing services for those in need (Lorentzen, 1994).

1.1 Background/actualization:

According to "Frivillighet Norge" (the Association of NGOs in Norway), the EU directive of 2014-24, effective from 2016, has brought up the question as to whether or not the public sector may continue to have closed biddings reserved for NGOs in the health and welfare sector. Frivillighet Norge conducted a survey in 2014 showing that non-profit organisations competing against private actors feel a higher rate of insecurity concerning their future. (Frivillighet Norge, 2014)

The Norwegian government ordered an investigation in 2014 to see what possible actions they had concerning the new EU directive. The author of the report concluded that it could be possible to form the criteria for awarding a contract in such a way that it would strengthen non-profit organisations in the competition. But the author also questioned whether or not non-profit organisations actually can provide something different or extra to a project compared to private actors. (Sejersted, 2014)

The Norwegian Directorate of Health has also started a financing solution to promote local cross sector initiatives. *Kommunalt kompetanse- og innovasjonstilskudd* (*Municipal expertise and innovation grants)* is intended to make it easier for local innovation in the health sector, and it is specifically aimed at volunteer organisations and interest groups specialised or focused on specific problem. The grant's main objective is to make it easier for smaller actors to finance project ideas. According to the Directorate of Health, it is important to understand how these actors act and successfully operate if these grants should be effective. (Helsedirektoratet, 2015)

The issue of gambling addiction has also resurfaced in the political debate in Norway. The amount of commercials for Internet gambling have increased in the past years and the Norwegian Media Authority have started looking into the regulations of gambling commercials and supervision of foreign TV-channels. (Medietilsynet, 2015)

1.2 Structure of this thesis

This thesis starts out with a litterature review to introduce the different topics the research touches upon. A more general introduction of innovation is followed by a more precises look at the literature on service innovation, including healt service innovation. Another topic concerned in this research, is the voluntary sector. There is litterature written on innovation in this sector from the field of public management, which emphasises the relationship to the public sector and the insitituinal enviornment of third sector actors. This emphasis is further explained by looking at the *social innovation* strand of Co-production. The chapter ends with an introdcution to litterature on the Norwegian voluntary sector and a summary.

The analytical framework is explained by presenting the two main research questions, followed by the explanation as to the choice of model used in the analysis of this case. The rest of the methodoloy chapter takes a part the research by explainng the choices in regards to research design, type of data used, selection of informants and how the data has been processed. The chapter is compleeted with thougts on additional considerations and a discussion the validity of the research and what could have perhaps been done differently.

Chapter 4 is a presentation of the data collected, by telling the story of the case. This chapter is based mainly on information collected through interviews. The chapter is split into different segments with some explanatory parts to important subjects, before the story is presented by looking at different parts of the process of developing gambling treatment in Norway. The case is presented with some jumps back and forth in time, looking first at the build up of gambling problems in Norway, then at the development of treatment and then going back to events leading up to the development of gambling treatment at Blå Kors Senter (BKS).

In the analysis chapter, the case is taken apart and reapplied to the *neo-Schumpeterian* model. Analysing processes that have been going on througout the treatment development is used to explain the different aspects of the case. The main foucs is on changes at the service provider building up to the introdution of the treatment service, but also on policy maker preferences represented by the public sector actor in this case. The last part of the model is the users, who

are not explicitly researched in this case, but assumptions by the other actors on user preferences has still affected the final charateristics of the service.

Following the analysis is a discussion on what indications or lessons this research may contribute with to the fields of service innovation, health service innovation and literature on tvoluntary sector innovation and on co-production. The thesis is finalized by a short conclusion in connection with the discussion.

2 Literature review of innovation and voluntary organisations

2.1 Innovation and types of innovation

This part will give a short introduction to innovation, with supplementary text on service- and health innovation.

> *"An innovation is the implementation of a new or significantly improved product (good or service), or process, a new marketing method, or a new organisational method in business practices, workplace organisation or external relations."*
>
> *(OECD/Eurostat, 2005, p. 46)*

This broad definition of innovation is used by OECD in the "*Oslo Manual: Guidelines for Collecting and Interpreting Innovation Data"*. It is a well-known definition, and it will with some specifications form the basis of this paper's interpretation and definition of innovation. Innovation may be considered to be a cornerstone of the human development; humans and humanity are always seeking new ways that can improve life. Innovation in academic thinking, especially in economics, did not have such an important place until the last century, when it became more distinguishable as an answer to economic and social changes. Innovation has become a cross-disciplinary concept used in different fashion (Fagerberg, 2006).

Schumpeter´s work forms the basis for much later literature on innovation. It will not be focused too much on his work directly, but his ideas provide some of the basis for the model used in the analysis, so a quick introduction follows, based on other references used in this thesis. Schumptere's early work focused on entrepreneurs and their ability to combine existing resources into new combinations, innovations. His later work also included innovation in large firms and the importance of this. Schumpeter discussed five types/forms of innovation; organisational, market, input, product, and process innovation. He also distinguished between radical innovations, something totally new, which brought with it considerable changes for actors, or incremental innovations which are only smaller adjustments to already available products (Fagerberg, 2006; Gallouj & Weinstein, 1997; Windrum & García-Goñi, 2008).

Not all innovation is about profits or getting an advantage in a competing environment. The incentives for innovation in the public sector may not be as clear as in the private sector, and it is also hard to promote innovation when the innovators and policy makers are far apart (Grimm, Fox, Baines, & Albertson, 2013).In the public sector and among non-profit actors innovation may still be important because innovation can be the solution to improving the services delivered, this can be done by applying product and service innovations. At the same time process innovation, to improve how services are provided, can important in these sectors, due to scarce resources and the hope to achieve as much as possible within the given economic constraints. Innovation in public services may not generate profit, but the improvements and new services may have a great impact on the many people affected, and it can over time benefit a welfare state under increasing pressure (Grimm et al., 2013; Tidd & Bessant, 2013, p. 5).

2.1.1 Service innovation

The main focus in this paper is on innovation in voluntary organisations and public services. Service innovation is a product innovation if we continue to use the OECD´s definitions. But services are not like other products. Goods are physical results of production and are therebye easy to see the existence of by both consumers and producers. Services on the other hand are products available to consumers, but they are non-physical acts or processes done by a service provider. Product innovations in the form of service innovations can be an improvement of existing services delivered or the implementation of new service to users (Gallouj & Weinstein, 1997, p. 540; OECD/Eurostat, 2005, p. 48).

Services make up a great part of the economy through revenue and workplaces they provide, and service innovation has taken on a more prominent role in the innovation literature during the last decades. Barras early on focused on how technological developments affected services, looking at how computer technology was applied in the service sector. The adaption of new technologies into services can provide an upsurge of new services depending on the ability of service providers to adapt the new technology. Barras proposed a “reverse product cycle” to explain how technology was used by service providers. The introduction of the new technology first of leads to incremental improvements of services in the form of efficiency,

going on to a more radical implementation of the technology improving the quality, and finally in the last phase the technology is used to launch a whole new product/service. Barras' theory showed how technology could explain innovation in services, but did not delve into the innovative processes leading up to the innovations in services (Barras, 1986; Gallouj & Weinstein, 1997).

> *"[I]t is essential to delve deeper into the "black box" of innovative processes to understand both their content and the forces that drive them." (Gallouj & Weinstein, 1997, p. 538)*

The view of a "reverse product cycle" to explain service innovation has been debated among innovation scholars. Gallouj and Weinstein (1997) point out that this view does only describe how technology is incorporated in services, and mostly appliable for technology depedent services(see also Gallouj, 1998). Those opposing Barras, state that a new service can be created without following Barras' trajectory, pointing to innovation in fields not heavily relying on technology in their service provision, such as consultancy. One example is the concept of ad-hoc innovation to explain a service provider's ability to solve a customer problem more or less on the spot. This term has yet again been debated for its lack of transferability(Gallouj & Weinstein, 1997; Windrum & García-Goñi, 2008).

> *" [I]t is less a theory of innovation in services than a theory of the spread of technological innovation from manufacturing to services"(Gallouj, 1998, p. 136)*

The Schumpetereian view on innovations was aimed at industrial innovation, and services were not included in Schumpeter's work, but there has since been done work to adapt these definitions such that they also can be used to understand service innovation. This has mainly been done by applying a characteristics apporach to innovation. Characteristics of products that are caused by known dynamics in innovation processes have been highlighted, and these characteristics have then been reapplied/ translated to services, showing the many similarities between goods and services. By using the characteristics approach, it is possible to research both services and goods in a similar fashion by looking at different aspects in the innovation process affecting the development and final result. According to Gallouj and Weinstein (1997), the characteristics approach can show the same types of innovation defined by Schumpeter in a service context. It further includes both the technological aspect of service innovation, but also includes other circumstances important in service innovation

such as competence (Gallouj & Weinstein, 1997). How the characteristics approach will become more evident when I elaborate on the dynamics of the model I used for the analysis of my case. But the analysis will not include a discussion on what type of innovation is researched. This has not been inclued since there are other subjects that are of more importance to this research.

Organisational processes leading up to the implementation of innovation in services has also gotten a lot of attention. Sørensen, Sundbo, and Mattsson (2013) categorise service innovation on a scale between two opposing approaches to understand different types of innovation. On the one hand are innovations that follow a top-down approach. They are usually planned and well-structured processes similar to typical industrial innovation. On the other side of the scale are innovations that are more unpredictable, *practice based*. These innovations usually come from the "front-line" of the service provider through bottom-up developments by employees taking on an entrepreneurial role. The two "extremes" are caused by different organisational conditions at the service provider. The *directed* version includes characteristics of top-down managerial processes, which are organised and intentional, developing innovations that usually are meant to solve general problems. Bottom-up entrepreneurial processes are on the other hand disorganised, perhaps non-intentional and are initiated by problem solving, leading to an innovation meant solve a specific problem, see also figure 1 in Sørensen et al. (2013, p. 1448). Both types of innovation can of course bring benefits, but the latter is harder to rely on for a service provider. Strategical considerations are necessary to try to ensure a good environment for such innovations. The research of Sørensen et al. (2013) indicates that there is a necessity for both a good *front office innovation climate* for the development of new ideas and at the same time a capable *organisational support system* to facilitate and integrate possible innovations.

By researching the establishment of pathological gambling treatment it is also necessary to look at some key elements of health service innovation. An important part of services in society is the distribution of health services. This type of services comes from the knowledge intensive health sector with a large degree of highly educated employees and actors. In the literature on health services, innovation is often credited to developments in the field of technology to improve medical procedures and possibilities, but another contributing factor is advancements in the scientific understanding of different health issues. The competence and knowledge of professionals is essential for the characteristics and quality of new services

(Morlacchi & Nelson, 2011; Windrum & García-Goñi, 2008). Health services will be further explained when introducing the model used for analysing this case.

2.2 The voluntary sector and public sector relations

2.2.1 Defining the voluntary sector

To explain the role of voluntary activity in the society it is useful to distinguish between typology used to understand voluntarism. Osborne does so early on in his book ”*Voluntary Organisations and Innovation in Public Services”* (1998a). The three different voluntary concepts are voluntaryism, volunteerism and voluntarism, and they differ on focus of concern and societal perspective. Voluntaryism relates to the organisation of society in general, and explains all activities being done on a *free* basis by actors, not organised or controlled by the state. It is closely related to libertarianism with the focus on free will and action as core guidelines in the organisation of society (Osborne, 1998a, pp. 5-14).

The two other expressions relate closer to the topic of this paper. Volunteerism describes actions made by an individual in society; a volunteer action is unselfish, unpaid and with the aim to benefit others in society or society as whole. Voluntarism is the institutional and organisational form of volunteerism. Organised volunteers and their volunteer actions combined is not necessarily voluntarism. The main point is that the core principles of a voluntary institution and how it is organised must come from within. It is independent of other institutions, and its own members must be the ones responsible for the organisation, governing its core principles, aims and how to achieve these. Voluntarism is by many seen as adding pluralism to society by operating in a space of society not controlled by the state or for-profit institutions. Voluntarism in the modern society makes room for alternative thoughts and voices with its free and independent values, which may be overflowed by the principle of majority rule in a democratic state. This part of society offers alternatives to the members of society, giving possibilities to seek help or give help in areas not covered by other institutions, increasing the diversity of society (Osborne, 1998a, pp. 5-14)

The value of independence has also made scholars assume that voluntary organisations should have an increased likelihood of generating new ideas and alternative solutions in society. Limitations caused by political and bureaucratic guidelines prevent alternative

developments in the public sector, but this may not be a problem for voluntary organisations because their operations are non-profit, independent and member-controlled. These three features, plus being formally constituted and having some sort of voluntary content, lays the foundation for the definition of voluntary non-profit organisations. This definition makes for a broad range of organisations, which again has caused the creation of the term *the voluntary sector,* also referred to as the *third sector*, *the non-profit sector* or *the independent sector.* The term indicates that the organisations operating in this sector are independent of the public sector of state institutions and the private sector of for-profit institutions. The term is debated among scholars for its lacking ability to show the diversity among institutions the term embraces, and their different aims and values. The term voluntary sector or third sector will nevertheless occur in this paper, to make a distinction from the two other sectors, and because it is used a lot in the general literature, both the Norwegian and English. (Brandsen & Pestoff, 2006; Dover & Lawrence, 2012; Osborne, 1998a, pp. 14-19)

2.2.2 Innovation and voluntary organisations

In the preparation for this research, literature specifically on innovation in the voluntary sector was consulted. It is researchers from the field of public management and organisational management who have written the major part of this literature. Osborne is one of the prominent researches on the subject, and has done several studies on the innovativeness of the British voluntary sector, one of the prominent one being (Osborne, 1998a). These studies are mostly of a quantitative nature, and do not provide so much insight into the specific innovative processes. Still, they contribute with lessons on innovation by voluntary actors, which can be valuable for this thesis. The major emphasis from these studies is on the importance of public- and voluntary sector relations. Public policy has a major effect on the economical and operational freedom of different voluntary organisations. Changes in policy with new ideas for how to promote certain results from third sector actors, brings with it several new terms and conditions, which ends up creating a difficult situation for such actors to plan ahead and make long-term decisions. This also leaves out the opportunities to take chances and try out new things. It is even argued that voluntary organisations capacity to innovate is not a result of their culture or characteristics, but rather a result of interactions caused by the institutional and policy environment (Osborne, 1998a, 1998b; Osborne, Chew, & McLaughlin, 2008).

2.2.3 Co-production

European nations are facing major challenges in the future, and the public sector may not alone be able to handle all the changes necessary to meet these obstacles. This increasing number of social, economic and environmental challenges may need new solutions to replace or improve current welfare systems. The increasing hope amongst policy-makers is that *social innovation* may bring along solutions that the former technological and economical driven societal development of the 19th and 20th century is unable to create. Social innovation is a broad term, and it is difficult to define because it is used to ”*refer to both the means and the ends of action*” (Grimm et al., 2013). Social innovation can be process-oriented, aimed at finding new ways to organise society to make it more capable of creating solutions. But social innovation can also be goal-oriented and be the novel solution that in itself solves a social problem. Some, including OECD, combines these two views on social innovation, aiming for it to be both a solution in itself, but at the same time enhance society’s ability to handle problems, social in both their means and ends. The vision of new ideas creating better social solutions is not new, but the intentional focus and the instrumentalisation of social innovation as a policy tool separates it from former policy methods (Grimm et al., 2013). Norwegian policy makers have also embraced social innovation as a possible solution for the future of the Norwegian welfare state. Throughout the spring of 2015 Innovation Norway organised several seminars under the slogan *Drømmeløftet*, one of these with the topic of social innovation and better cooperation between the public- and private sector, and how this could enhance the Norwegian welfare state in meeting future societal problems(Innovasjon Norge, 2015).

Policy makers are not the only ones who have picked up on social innovation. People from different academic disciplines, such as organisational, environmental, and entrepreneurial studies, have also shown interest for the topic, thus creating even more under-categories or genres to the theme. For this paper the focus will be on how it is viewed in the field of social policy, and especially the topic of co-production. In social policy the term social innovation concerns the possibilities created by new forms of governance and the involvement of external actors such as the users in development of new and better solutions (Grimm et al., 2013).

Co-production is part of the process-oriented strand of social innovation aiming to organise society in new ways to create better solutions. Osborne and Strokosch define co-production broadly as:

> *"Long-term relations between professionalized service providers (in any sector) and service users or other members of the community, where all parties make substantial resource contributions"(Osborne & Strokosch, 2013).*

Originally co-production referred to any involvement by citizens in the development of public services, but later the definition has been split into the three main categories of co-governance, co-management and co-production, and thereby broadening the scope of the first definition to third sector involvement as well:

- *Co-governance* refers to an arrangement, in which third sector participates in the planning and delivery of public services.
- *Co-management* refers to an arrangement, in which the third sector produces services in collaboration with the state.
- *Co-production*, in the more restricted use of the term, refers to an arrangement where citizens produce their own services at least in part. The latter could also refer to autonomous service delivery by citizens without direct state involvement, but with public financing and regulation.

As presented in (Pestoff, Osborne, & Brandsen, 2006, p. 593), see also (Brandsen & Pestoff, 2006, p. 497)

These three categories may be distinguished along two strands; the distinction between organisational and individual level, and a distinction along the policy cycle between planning and production. Co-management is related to the organisational work, while co-production focuses on the voluntary effort of individuals. In terms of policy, co-governance is more focused on policy formulation and the other two focus on the implementation (Brandsen & Pestoff, 2006). Co-production implies collaboration between service provider and client (usually public sector), an "integrated outsourcing of public services". Service provision on behalf of the public sector without cooperation between sectors can also occur, but this does not fall under co-production, these are purely contractual relationships, "total outsorcing" realtionships (Windrum, 2014, p. 1049).

Co-production is closely related to user-led innovation, but in this paper the focus on co-production will be on how the public sector cooperates with the voluntary sector, and not on the involvement of users in service innovation as the term is used in other literature.

2.2.4 The Voluntary sector in Norway

The emergence of greater national voluntary organisations started around the year 1840 in Norway. The early organisations were usually rooted in a moral stance such as missionary work or the temperance movement. Later voluntary organisations were more aimed at societal issues, health and welfare. Blå Kors (Blue Cross) being one of these, established in 1906 in Norway. It did not take much time for a relationship between these voluntary organisations and the public sector to develop. From early on the public sector relied on the aid of organisations to help out with societal problems such as poverty, giving organisations the task as the middle-man distributing municipal and private funds to the needy (Lorentzen, 1994, pp. 180-181).

Different shifts in policy through the years forced many organisations to give up their work to the municipal authorities, becoming pure interest groups, or they would change their character towards that of a private institution delivering services on behalf of the public sector. Lack of political cooperation between the voluntary organisations or any umbrella organisation gave the policy changes little opposition, the political views of an actual voluntary/third sector did not become apparent until the early 1980s (Lorentzen, 1994, pp. 181-193).

Although the scepticism towards external institutions has weakened, the public sector still seems reluctant to engage in too free cooperation with voluntary organisations. Public institutions may seem willing and open for cooperation, even going quite the lengths in the form of allowing exemptions from normal policy, but in the end the final result will be the choice of exit or loyalty; *"terminated cooperation or full integration with the public, with little space left for one's own work methods."*[1] (Lorentzen, 1994, pp. 208-212).

[1] Personal translation

Since the 1980s researchers have seen changes in how voluntary organisations operate in Norway. Citizens wanting to contribute with voluntary work have changed in their view as to how and where to do such work. People follow a "right here, right now" attitude towards voluntary work, ignoring the culture of taking part in the decision processes of organisations, and instead just doing something they find meaningful. Academics on the field ascribe these changes to a shift in society where time consumption weighs more in on people's choices. Volunteers wish to have their respective duties handed to them in such a fashion that the action itself becomes the centre point of the voluntary contribution. Traditional voluntary work with meetings and involvement by the members cannot meet the current demand of efficiency. This trend is also visible through the decrease in paying members and number of active organisation members at decision meetings, which is important to sustain the democratic cornerstone of the organisations (Gulbrandsen & Ødegård, 2011, pp. 13-16).

> *"The individualistic orientation seems to result in less patience for meetings and time consuming democratic procedures. A result of this is that a number of citizens prefer to provide voluntary efforts without being members and committing to long-term obligations."*[2] *(Gulbrandsen & Ødegård, 2011, p. 15)*

These changes have impacted the organisational culture of many voluntary organisations. It has become necessary to enlist professional employees to do administrational duties. The lack of active members makes it hard to sustain the former culture of dividing such tasks among volunteers. The professional administration manages and facilitates to a large degree the voluntary work on behalf of the volunteers. Some authors describe this trend as a professionalism of the organisations and a form of "organized individualism" (Gulbrandsen & Ødegård, 2011, pp. 7 & 16-23).

Decreasing influx of members combined with the fact that studies show a shorter timespan for members to stay in an organisation, means a lower total of members, this has become a challenge for organisations. The amount of public funding is usually connected to the organisations number of members, and it is also a measurable quantity for the "success" of the organisation affecting its legitimacy in society. Funding from members and private donors are no longer enough to keep the organisational machinery, at least not with the new

[2] Personal translation

administrational costs(Gulbrandsen & Ødegård, 2011, pp. 7 & 16-23). So where has the third sector turned for funding?

Today a greater part of the funding comes through public channels. At the end of the 1990s it was reported that about a third of the funding for voluntary organisations in Norway came from public sources. There is no curtain numbers, but it is highly likely that this number has only increased alongside an improving interest towards the third sector by policy makers. The public voluntary policy makes up the fundament for the relationship between public- and third sector organisations, and decides in many ways a lot of the framework in which the voluntary organisations operate, and also in Norway studies show that continous policy changes are percieved as difficult by voluntary organisations, having to adapt to new regulations and demands all the time(Gulbrandsen & Ødegård, 2011, pp. 37-43).

2.3 Summary

This chapter has tried to give insight into the academic literature on subjects that are relevant for this thesis. The case researched extends in different directions when it comes to field of study, and it has therefore been necessary to include literature on different topics to provide an understandable starting point for the reader.

The focus in the field of innovation is on service innovation, more precisely on health service innovation. The subject of service innovation is still in a "fuzzy" phase of development, with continuous contributions from different scholars. But service innovation has become more palpable through research in the field and adaptations of theories from regular innovation literature. A lot of research is done on the health sector, and health service innovation distinguishes itself in some parts from other sectors, because of its knowledge intense nature and high demand for competence among actors operating in the sector.

The voluntary sector is a definition used to gather organisations and actors operating separately form the private and public sector. These organisations operate on a non-profit basis with the aim of positively improving certain things in society, but the definition is debated because of its lacking ability to show the diversity among those defined within the sector.

Public policy makers in recent years have been attracted to the subject of *social innovation* as the answer to future societal problems. Among solutions included under that subject is co-production. The public sector is believed to rely on other actors to provide all necessary public services in society, among these possible actors are voluntary organisations. Actors from the non-profit sector are believed to have an inherent ability to innovate and create new ideas, due to their independence and lack of restrictions. But at the same time literature on voluntary organisations is quite definite as to the importance of good public sector policy and relations for the survival of such organisations and their ability to operate and innovate.

In Norway the public sector has a long history, but it is also a history of shifting difficulties due to public policy. In later years the decline in number of members and lack of interest by volunteers, has forced voluntary organisations to be more dependent on financial support from the public sector and also to professionalise by hiring full-time employees.

3 Methodology[3]

3.1 Analytical framework

3.1.1 Research questions

The aim of this paper is to study innovation in the voluntary sector in Norway. The research has been narrowed down to the case of gambling treatment in Norway and how this developed at Blå Kors Senter. The hope is to find answers as to what happened in the innovation process, which today seems to have been a success. Based on literature written on the field of both service innovation and about the voluntary sector, internal processes at the service provider, dynamics between actors, the organisational environment and especially the relationship to the public sector will be concentrated on.

I hope to answer two main research questions:

- How did treatment of pathological gambling develop in Norway?
- How did the resulting treatment service end up at Blå Kors Senter?

By searching for answers to these two questions the hope is to observe what dynamics where in action during the innovative process of the treatment service. Secondly understanding how it ended up in the voluntary sector under the Blå Kors organisation. Findings from a research on this particular innovative process can perhaps provide some lessons or ideas for both the service innovation literature and those interested in the voluntary sector, especially in Norway.

3.1.2 A neo-Schumpeterian framework for health services innovation

To research and understand the development of gambling treatment at Blå Kors Senter in Norway I have sought to the innovation literature. In the field of service innovation, there is literature specified to explaining service innovation concerning advancements in the health sector. These models share some common features considering focus on learning by doing, interaction of different actors and knowledge flows. Despite concerning primarily service

[3] Chapter based on the master thesis outline TIK4040 exam 2015.

innovation they often tend to include technology in some sort of fashion, either as part of the innovation system or technological advancements as an important part of the development. To mention two possible models; both Morlacchi and Nelson's model of three co-evolving pathways (2011) and Consoli and Mina´s health innovation system (2009) were considered as analytical tools for this paper, but were discarded for a third model because of their technological aspects.

In the case of Blå Kors and treatment of pathological gambling, the service provision is not as connected directly with technological advancements, as it seems, but is a non-physical treatment from the field of psychology. To adapt this case study and the form of service innovation into the literature it was necessary to seek a model that focused on network interaction between actors connected to the new service. Windrum and García-Goñi (2008) have created a model to explain health service innovation. The model is based on a framework originally formulated by Saviotti and Metcalfe focusing on the relationship between the process-, technical- and service characteristics in manufacturing innovation. Gallouj and Weinstein then further adapted the model to focus on service innovation, by using the previously mentioned characteristics approach to services. Windrum and García-Goni's *neo-Schumpeterian model for health service innovation* has extended the mentioned models by applying new actors and applying factors of competence to the model. The latter is based on Barras' focus on the importance of competence at the service provider (Windrum & García-Goñi, 2008).

The structure of the model

The *neo-Schumpeterian model for health service innovation* is a multi-agent model that includes the actors: service provider, policy maker and the service user. The model is based on the characteristics approach and the actors are represented by their preferences (SP, PP and UP) and how they affect the characteristics of the service (S), see (Fig. 1). Connected to the three actors' preferences are also different competences. The service provider´s preferences are affected by changes in the *Back office competences* (SCB) and *User facing competences* (SCU). The policy maker and service user have only a single competence connected to their preferences (PC) and (UC).

Back office competences include organisational change at the service provider, such as changes in daily routines or change in staff. User facing competences is the level of

knowledge, skills and techniques possessed by those working on the "front line". Among these inputs, the models creators have included technology, decreasing its importance in the model(Windrum & García-Goñi, 2008).

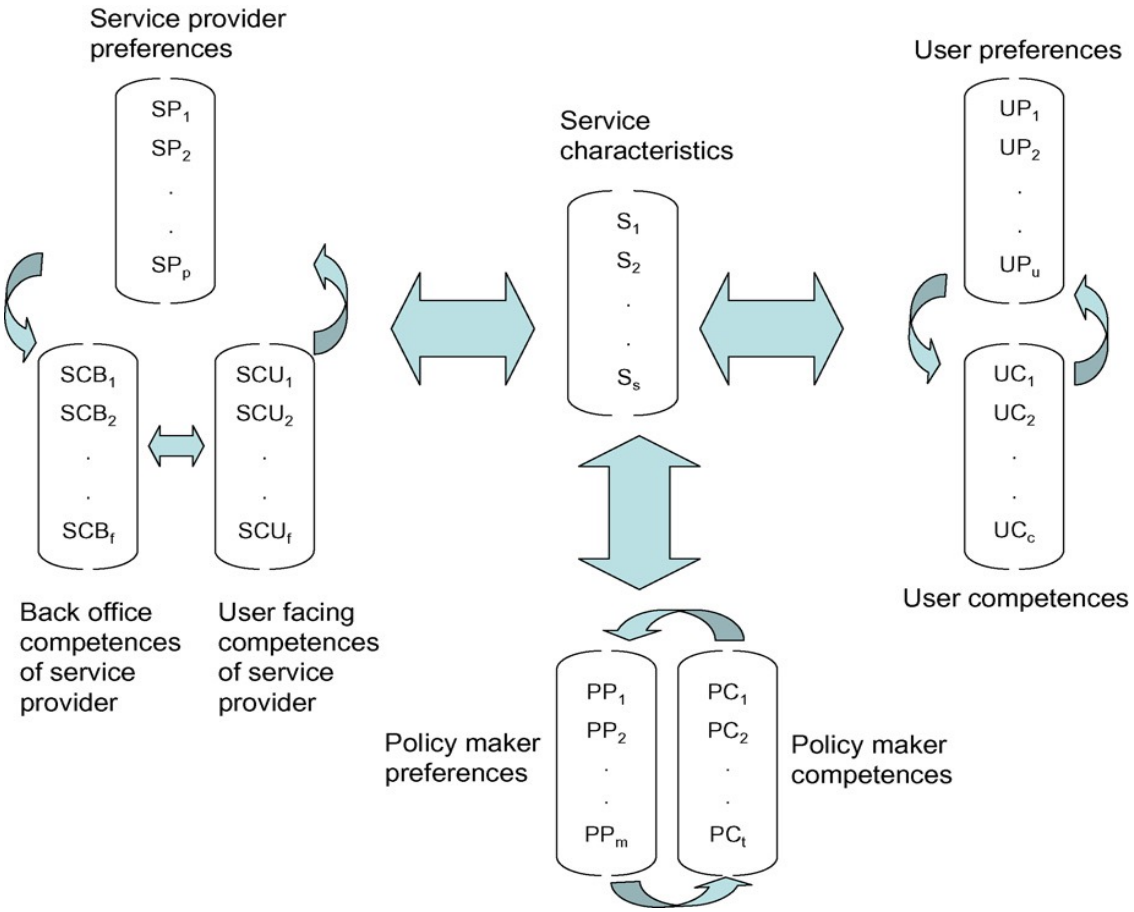

Fig. 1. Operationalised model of the neo-Schumpeterian framework of health service innovation (Windrum & García-Goñi, 2008, p. 660)

Benefits of the model

The reason to choose this model for this research is because of the possibilities to research several interesting parts of the innovation process that seems important in this case. A benefit of using this model is its focus on human capital and the actors' relations to the service. The literature indicates that there are important linkages between the third sector and the public sector, so a model including both actors would greatly benefit the research. The hope is also to investigate how the organisation Blå Kors ended up with gambling treatment, so inter-organisational incidents and actions may have had an impact, which then can be included in changes observed in the *Back office competences* and *User facing competences.*

The models creators also promote that it is possible to capture all the forms of innovation defined by Schumpeter, which explains the name of the model. All the innovation types should be possible to register in change of characteristics in some or all parts of the model(for an in-depth explanation: Windrum & García-Goñi, 2008, pp. 656-657). This will not be focused on in the analysis, since there must be made decisions as to what is important for the aim of this research

The model also makes it possible to look at the organisational conditions focused on by Sørensen et al. (2013) and how they may have affected the innovative process. Changes in *user facing competence* in combination with *back office competence* can with some additional insights provide a picture similar to the *front office* and *organisational support system* that those authors present.

In summary the model fits well with what this research wants to examine. All possible actors are included that seem to be important in both service innovation and literature on the voluntary sector. The model is aimed at health services, but is at the same time not focused on technology. It also opens up the possibility to discuss what kind of innovation is being researched within Schumpeter´s well known definitions. Finally, the organisational environment can also be discussed through the included competences of the service provider.

Possible deficiencies of the model

The model is based on the characteristics approach, making it possible to say a lot about what affected the innovation and the final service. But the model fails to include the actual process of innovation, only providing elements that are surrounding the process. The creators also use Barras' theory of service innovation, with the "reverse product cycle", as one of their principles(Windrum & García-Goñi, 2008), which perhaps is rather contradicting since it is a health service innovation model that has given technology a less important position.

3.2 Research design

This research is a qualitative case study about the development of gambling treatment at Blå Kors Senter. The research is based on eight interviews with a mixed group of informants. Some of them are firsthand sources with a direct linkage to the case researched, while other

informants are included because of their knowledge and inputs relating to this case. The broad range of informants has given diverse insights from different angles and positions.

To understand the different social dynamics that played out in the innovative process I chose a qualitative research approach, a case study, as this gives a foundation to go in depth of the social phenomenon we study. Justification for choosing a qualitative approach is that it highlights processes and opinion making that cannot as easily be quantified, and one can gain a great deal of information about few entities (Thagaard, 2009, p. 17). The goal of a case study is to collect rich information on the case in question. Case studies aim to focus on and analyse one or more units connected to the subject of research. These units can be people, groups or organisations. Case studies should aim to collect research that is transferable to other domains or other parts of the domain, and based on the research results possibly give an indication of similar trends in the field of research (Thagaard, 2009, pp. 48-51, 210-211). This should make it possible to observe the dynamics and interactions that I believe can explain something about what was essential for the success in the development of the gambling treatment. Qualitative methods also allows for a flexible research structure, and to go back and forth between configuring research questions, data collection, analysis and interpretation as the research progresses(Thagaard, 2009, pp. 11-14 & 30).

I will follow a systematically approach, and try to provide a reflected aspect of my methodological decisions. Therefore I will now inform of and explain decisions made throughout the research process (Thagaard, 2009, p. 15).

3.2.1 Approach

I was aiming to find informants that were close to the events surrounding the development of the service in question at Blå Kors Senter (BKS). I started with contacting the administration at Blå Kors, explaining my initial ideas and what kind of informants and information I was seeking. I already knew that the case and events probably had occurred somewhere around the turn of the millennium. The hope was to get some recommendations on possible informants. The administration provided me with some persons they believed could be interesting for me, either as informants or optionally getting me on the right track. The hope was that by finding at least one person that had firsthand experiences to the case, this could

lead me to other informants of the same relevance using the so called *snowball sampling* method (Thagaard, 2009, p. 56).

This gave successful results, and my first informant was a firsthand source. The informant gave me such a wide range of other informants to get in contact with, that I had to do an elimination rooted in their probable value for the research. This selection was made based on the possible informants role in relation to the organisation and development of the treatment. Early on I found that I could make a distinction between possible informants related to the development of the treatment, and on the other hand informants related to the political debate surrounding gambling problems. This made the further search for informants easier. The new informants able and willing to participate gave further recommendations on finding relevant informants that I did not already know about.

Throughout this research I have been very lucky with the cooperation of my informants, and this must be credited as valuable for the work on this thesis. All informants have been positively inclined to do interviews. I partly credit time for the ease I have encountered during this research. The case in question happened over ten years ago, and my informants talked with ease about it and many of them pointed straight out that what they said could not possibly be controversial today, so the credibility of their truthfulness cannot be questioned to harsh. I also believe that by researching the voluntary sector, which must be believed to attract a certain amount of people with the aim of helping others, I have had the benefit of a higher rate of positively inclined informants to help out and willing to participate in a research done by a confused master's degree student.

3.2.2 Challenges

The type of data I believed to have relevance for this research, were interviews and possible organisation documents. As the research progressed and I got hold of some documents from Blå Kors, it became apparent that most of their public documents, such as annual reports, were not very detailed in the areas I sought information. They were also organized in general reports for several years at the time, making it even more difficult to find information that could provide insight into specific incidents. At BKS the administration consists of many

new employees, so they answered me that they were not able to find anything specific in their archives.

The events I wanted to research took place more than 15 years ago, which made for some obstacles related to localizing and identifying informants. The first hand sources that I wanted to get in touch with had over the years left the organisation or taken on new positions and/or moved away. This made it some times difficult and challenging to locate them. In some cases it was necessary to do some investigation to find the right persons and the correct contact information. Internet, combined with crosschecking information eased this. I some times had to call different institutions to ask if they knew how to get in touch with person X, well aware of my ethical obligations, I did so without revealing the intention of contacting them.

Other challenges have been related to the time in which the research took place, as it has been done over the summer. This resulted in difficulties when trying to get in contact with some informants and some interviews had to be postponed due to informants absence by being on vacation or not available at the time.

3.2.3 Ethical considerations

By using the *snowball sampling* method, asking informants about other possible informants, the new informants introduced are not able to give their opinion about whether or not this is fine with them. I could have solved this by letting the original informant contact the "new" source to confirm that they were willing to participate(Thagaard, 2009, pp. 56-57). This would possibly have been a quite time consuming task since I at times got information about groups of informants. Instead I took the approach of verifying that the original informant was comfortable and willing to let me mention them as the source. This was then used in the initial contact with new informants when asking for their participation.

All informants received a document, based on NSD guidelines, explaining the research and what their partaking would mean. Individually it was agreed upon with every informant what I could use in the thesis, and those who requested anonymity or citations check were of course given this. A written consent has been received from all the participating informants.

When researching the health sector, one may meet problems related to patient confidentiality, and the aim was to avoid this by focusing on the service provider and not the users. But during the interviews there have been some unforeseen encounters of information/stories relating to former treatment users. The informants have not been encouraged to tell stories of such nature; they have just arisen during interviews. These stories have not been in any form included as data for this paper and such stories are also left out of notes or transcriptions from interviews.

The research was reported to *NSD – Norwegian Social Science Data Service*. The research was approved after some revision of the participant information slip. Data collected during this research will after the submission of this thesis be anonymised.

3.2.4 Validity and reliability

The time aspect of the case researched has its implications on the memory of the informants, and the possibility of so called *recall biases*. One cannot assume that firsthand oral sources instantly give a correct perception of the past. There is a possibility for wrong recollection or simple forgetfulness, but on the other hand there is no "simple linear connection between timespan and forgetfulness"(Kjeldstadli, 1999, p. 196). The subject of memory and recollection is vast, and I will not elaborate more on this except that it is important to be aware of the possible implications on the research. This has been a worry throughout the research, but as more data got collected the more I could validate and compare the information at hand. The information collected from the informants is based on their experiences and views, but the researcher interprets this information further based on his/her academic background. This leaves the information collected after being analysed not to describe the informants' interpretation, but rather the researchers interpretation of this interpretation(Thagaard, 2009, pp. 142-143).

In literature on health service innovation, the role of the patient/*user,* is an important part of explaining the development. The choice not to include these actors in this research was done because of time limitations and the difficulties of patient confidentiality, as mentioned as an ethical consideration. These actors could probably have contributed with valuable information on *user preferences* and given the research other perspectives.

The rather unison view on gambling and development of the treatment by the participating informants, raises the question of the lacking inputs by possible opposing informants. Informants with another view on gambling in Norway, or perhaps on how to treat pathological gambling, and informants from other institutions than BKS also providing gambling treatment, should perhaps have been included to give another view on the case.

3.3 Data

3.3.1 Interviews

The interviews were based on a semi-structural interview guide, making it possible to conduct exploratory interviews. This meant that I had some questions and themes prepared for every interview, but the idea was that the informants should tell their own story and recollection of the events. Kvale's argument is that if the goal is to have a narrative form of analysis, the interview objects should have the possibility to tell their story(Kvale, Anderssen, & Rygge, 1997, p. 77).

Conducting the interviews also became a learning process for me as a researcher. After conducting some interviews I observed some trends. One was that by not immediately asking a question when the interview object was finished with a long line of reasoning, it was a possibility that they contributed with additional information that they had presumably forgotten. I also noticed that I had to be careful when using the term innovation, as this seemed to trigger diversions to all kinds of irrelevant projects.

The interviews were done in person or on the phone, all interviews were taped by using a recorder of some sort, or in the case of phone conversations they were documented by using an application recording the conversations. The choice of accepting phone interviews was because it in some cases was the only way to conduct them, the researcher not being able to travel to the informant or the lack of time available for some of them. Most of the interviews went according to plan, but two of the interviews by phone suffered from disruptions due to bad connection. This made the interview situation a bit hectic having to realign between every interruption, but the informants did not seem to mind too much.

3.3.2 Informants

	Name	Background or position	Date	Approximate duration
Informant 1	Hans Olav Fekjær	Retired psychologist	5.6.2015	80 min
Informant 2	Geir Gundersern	Former Secretary General of BK	3.8.2015	30 min
Informant 3	Halvor Kjølstad	Former director at BKS	12.8.2015	30 min
Informant 4	Jan Elverum	Current Secretary General of BK	13.8.2015	47 min
Informant 5	Rolf Brumoen	In charge of gambling at BKS today	17.8.2015	45 min
Informant 6	Anonymous informant	Former active gambler	21.8.2015	41 min
Informant 7	Marianne Hansen	Psychologist	1.9.2015	42 min
Informant 8	Kristoffer Persson	Division director in Oslo´s department of welfare	2.9.2015	30 min

Table 1: Interviews and informants

Short introduction of the informants

Fekjær, Kjølstad and Hansen, all of them psychologists, worked at BKS during the development of the gambling treatment. Both Fekjær and Hansen have also done research on the subject of pathological gambling and treatment.

Geir Gundersen was the Secretary General of Blå Kors in Norway from 1998, the time period of this case. His predecessor Jan Elverum took office in 2011 and still holds this position, before this he was director at another Blå Kors treatment institution, Lade Behandlingssenter.

Brumoen is the one academically responsible for gambling treatment at BKS today. Previously, he worked at several different addiction treatment institutions in Oslo. He is educated as social worker and has taken a further specialization on gambling.

Kristoffer Persson is a division director and works in the department of welfare in Oslo. He has 25 years of experience in the public sector, and at the time of this case, he was responsible for the procurement of services for substance abusers from the private market.

A former active gambler who will remain anonymous was included to give a perspective on the situation in Norway at the time of this case and a grasp of how it is to be a pathological gambler. The interview gave valuable insight into the informants experiences and opinions on the case, but it was agreed upon to not cite too much of the interview in this paper.

Some other possible informants were also contacted, but different circumstances made it impossible to conduct interviews. I still believe that the informants included in this research provide a credible basis for this research. They are closely related to the case or well enough informed about the topic, and they cover the case from a variety of perspectives.

3.3.3 Processing the data

The analysis is mainly based on the interviews made since the social interactions and connections between actors are the main focus of the research, which is best reflected through qualitative data. Most informants share the same memories of the innovation process, although there are some differences depending on their position and role in the case.

After conducting the interviews, they were listened through once or twice using a transcription program, and important parts and citations were transcribed. The reason for not transcribing entire interviews was due to the cases of off-topic content, such as parts that included sensitive information like former patient histories (explained under *Ethical considerations)*. After collecting *all* the data, the interviews were re-listened to assuring that possible information that earlier not seemed to be of great significance, perhaps now was relevant. To make the entire interviews possible to revisit, the recordings will be kept after being anonymised and sensitive information will be edited out.

The information collected from the interviews was put into a matrix listing things of importance for the success of the service introduction and how the informants weighed these. The model used for the analysis was already divided into different structures with certain qualities, making it possible to adapt elements from it into to a scheme to process the data. Based on the model the data was separated into different categories, such as putting information about managerial changes in a category related to *back office competences*. The

matrix and the categorization were guiding tools in the process of understanding the data. This was done to give a more concrete picture of the gravity of various aspects of the process and view possible trends (Thagaard, 2009, pp. 149-153).

Considering the validity of this process, the informants did never rank their opinions or share all the same inputs. This means that the inputs and how they were categorised was based on interpretation and collection by the researcher, as discussed under 3.2.3.

3.3.4 Additional considerations

Language

All interviews were conducted in Norwegian since this eased the interview process. The level of English mastery in Norway is high, but it was decided that interviews in English would compromise on time and perception. This has of course lead to a translation gap between interviews and this thesis written in English. With more time at hand I would have invested the time and perhaps finances to confirm my personal translations with professionals. Most of the data collected through the interviews is auto-translated within the written text. The exception is citations collected directly from the different interviews. These have been translated as best from Norwegian to English trying to change them as little as possible from the original citation, but with some alterations to make them sensible to the reader. This of course, is a balancing act to not include too much of my own interpretation of what is said and to make the citations understandable.

Field of study

As the research progressed and interviews were conducted, it became clear that I was heading into the unfamiliar territory of psychology and addiction treatment. My informants did well to clarify possible confusions during the interviews and I have also sought to explanatory literature to understand definitions and expressions that have been encountered. Alas this thesis must be understood as it is, written by a student far from the field of psychology and addiction treatment, and this will have its limitations on the validity of such content.

4 Blå Kors and the treatment of gambling addiction

This chapter will present the case and tell the story of how gambling treatment developed in Norway. The chapter starts off with some introductory parts on different subjects to form a basis to understand the main part focused on what more specifically went on at Blå Kors Senter. The following chapter will take a part the story told and analyse the different incidents of the case.

This chapter is heavily based on the interviews conducted, citations are also included within the chapter, marked with the informant who stated so during their interviews. Additional references that have been used along side the interviews are explicitly marked according to usual procedures.

4.1 Blå Kors

Blå Kors Norge (Blue Cross Norway) est. 1905 is a Christian organisation that promotes a drug and alcohol free society. The organisation does so through treatment of addiction, preventive work and raising awareness. Their main objective has been to help alcohol and drug addicts, to spread an intoxication free lifestyle and to reach out in society with the Christian message through words and action. Blå Kors combines voluntaries and professionals in their work. On the professional side, Blå Kors owns 52 diaconal clinics throughout Norway (2015) (Glimsdal, 2015; Gulbrandsen & Ødegård, 2011, p. 109).
The following are the most updated numbers from Blå Kors Norge:

Numbers from Blå Kors Norge

Revenue/turnover (in 1000 NOK) 2011:		710.493
Revenue/turnover (in 1000 NOK) 2012:		729.036
Revenue/turnover (in 1000 NOK) 2013:		763.016
Number of patients/users/ residents/pupils/guests in 2013:	**8.484**	
Outpatient consultations in 2013:	**22.830**	
Overnight bed posts:	**421***	

Number of employees:	**1.091***
Number of FTEs (Full Time Equivalent):	**857,4***
Number of volunteers:	**265***

*Pr 31.12.2013 (Blå Kors Norge, 2014b, p. 20)

It will become apparent further on in this paper that Blå Kors is a mixed organisation, and that it may be said to operate in a grey zone of what can be understood as the private and voluntary sector. The role as a voluntary organisation must be discussed because of the relationship as an owner of clinics operating on behalf of the public sector alongside private actors.

4.2 Gambling

"Pathological gambling causes problems on different levels. The gambler him or her can be affected by reduced physical and mental health and ruined economy. The gambler's family and friends often suffer broken relationships. Society as a whole is affected by reduced participation in employment and the cost of treatment and social assistance. " (Hansen, 2006, p. 94)

Gambling can be defined as risking something of value in the hopes of regaining an increased value. Today this is mostly understood as betting and wagering in casinos, lotteries, sports events and such. Many people gamble, but some get addicted, or as it is called in professional terms, they become pathological gamblers. There are many causes and differences between how gambling develops to pathological gambling among people, and between the regular gambling and the pathological gambling is also the more moderate and blurry form of "gambling problems" with similarities although less-severe. (Hansen, 2006; Potenza, Fiellin, Heninger, Rounsaville, & Mazure, 2002)

"Pathological gambling […] represents the most severe pattern of excessive or destructive gambling behaviour […]" (Potenza et al., 2002, p. 721)

Pathological gambling is placed on a spectrum between compulsive disorder and addiction due to different conceptualizations. But the understanding of pathological gambling as the

latter is the focus of the paper "*Gambling*"(Potenza et al., 2002) and is also supported by my informants. Pathological gambling bears several similarities to substance abuse and other forms of addictions. Some similar genetic factors have been observed, and there are common patterns in how neural systems contribute to both drug and gambling related behaviour. Hansen sums it up as an addiction based on the many similarities in the processes involved in other forms of addiction. On the technical level there is dopamine involved, and gambling stimulates the neurochemistry in the brain without adding substances to the body. It also involves an escape aspect, leaving troubles and thoughts behind when gambling. The addict can become nervous when not gambling, it is a pervasive activity and a lot of time goes to planning for the next bet or game and gathering money. Pathological gamblers also experience relapses and abstinence with strong physiological tendencies of shivering, sweating and unrest such as from substance abuse. (Potenza et al., 2002, pp. 722-724)

"Pathological gambling is an addiction which does not involve supplying the body with a substance, albeit an addiction." *- Hansen*

In this paper there will not be made any distinction as to the level of gambling problems. The terms gambling, gambling problems, pathological gambling and gambling addiction will be used interchangeably throughout the text, partly due to the inexperience with the field and because the latter is closer in translation to the most well-known term in Norwegian, *spilleavhengighet*. As mentioned in chapter 3, during my research I have partly glided into the field of psychology. The introduction of both gambling in general and treatment of pathological gambling may have some shortcomings due to the author´s inexperience in the field.

4.3 Gambling in Norway

Gambling problems in Norway were at the start of the 1900´s a great social problem caused by card games such as poker. Family tragedies were caused by people betting away, not only their income, but also real estate such as houses, farms or animals, robbing their families of household and income possibilities. Generations later, stories of former family members or other local gambling tragedies were still being told, leaving card games and gambling with bad connotations and not fitting with social values at the time. But both politics concerning gambling and popular opinion tends to shift over time. After times of liberalization, comes restrictions, and after some time the restrictions ease up and the liberalization returns, this

also happened in Norway. After the Second World War there was a steady increase in sanctions given out by the government, opening up for legal betting and lotteries, and also the establishment of the national lottery company - *Norsk Tipping* – in 1948. The argument was that profits from such operations could benefit society by being forwarded to non-profit organisations and other good causes (Fekjær, 2002, pp. 29-34).

"... It has always been the pretext to legalize gambling. Initially one has thought that gambling is not good, but that this is outweighed by what the profits goes to. The good cause." *- Fekjær*

This tendency culminated in many ways with the upsurge of slot machines during the 90´s. Before this there had been some machines one could bet on, but these were of moderate character, both on a technological level and as to the amount one could bet or win. New computer-programmed machines entered the market, with the possibility to take large notes and with possibility to win larger sums of money. The slot machines became very profitable, and the tendencies in the market resembled a *gold rush*, the number of machines escalated quickly. Some non-profit organisations were offered the benefits form such income, but refused, while others approved of it (Fekjær, 2002, pp. 29-34).

This paper will not go into detail on the political debate between organisations receiving funding through gambling and those who opposed it, but it was clearly a heated debate at the time, and my informants representing the opposing side are all very clear as to what they think about the organisations which did use this income form. All in all, this situation shows the problems of using a definition such as the voluntary sector since it does not grasp the diversity between organisations in the sector, and perhaps gives a false impression of unity among such.

The main contribution to gambling in Norway at the end of the 90´s became the slot machines, which were to be found all over the country. The typical location would be at the supermarket or a local store. Numbers from 2003 gives an indication to the problem; at the time Norway had 17,500 slot machines, equalling four slot machines per 1000 people. (Fekjær, 2002, pp. 29-34; Hansen, 2006)

"I remember being at a meeting in Germany and I met some other gambling addicts, they said they had been on holiday in Norway, and that they perceived the grocery

stores as mini-casinos […] Because that was what it was, and for a compulsive gambler to walk into a mini-casino to buy a litre of milk or a bread, it didn´t make sense"

- Anonymous informant

With many slot machines in close vicinity to most of the population's daily habits and chores, the problem was starting to become apparent for most Norwegians:

" […]You know, the whole population noticed that some sad looking people were standing there [at the slot machines] as they went in grocery shopping, and they were still standing there as they came out again, looking as if they were attending their own funeral, so it became very apparent for the population."

- Fekjær

4.4 Treatment of gambling addiction in Norway

At an international conference in Amsterdam about substance abuse problems in 1996, the topic of gambling addiction was one of the topics discussed, a new subject. Among the participants at this international conference were two Norwegian psychologists, Hans Olav Fekjær being one of them. This new subject on problems with gambling aroused the interest of both participants as they went home to Norway. One of them acted on the subject a short time after his return. To find out whether or not someone did offer treatment on gambling in Norway, he contacted the public sector, after several phone conversations and being passed on in different directions in the system, he finally arrived on the other end of someone asking the question: "Does it relate to all kinds of musical instruments?". A confusion caused by the similarities between the Norwegian word for game or gamble, *spill*, that also is another word for play, as in this case playing an instrument. Although an entertaining anecdote from the start-up in Norway, it clearly shows the lack of knowledge on the subject at the time in Norway, at least in the public sector.

Anyhow, in 1997 the psychologist managed to start up a 3-year project for treatment of gambling addiction at Renåvangen, a treatment institution for alcohol and drug related problems. Based on experiences from other treatments at Renåvangen and in cooperation with a clinic in the Netherlands, seeking knowledge where they could find it. This was the first gambling treatment program in Norway, and laid the foundation for further expansion. (Hansen, 2006)

In 2000 Blå Kors Senter (BKS), in Oslo, also started up with a treatment program for gambling problems. Hans Olav Fekjær, the other participant in Amsterdam, and Marianne Hansen were leading the project. Their arrangement was a bit different form the one at Renåvangen, which was a two times 1 week program more like a treatment *course* as Hansen remembers after observing it. Blå Kors Senter sought to introduce an outpatient alternative. They focused on cognitive behavioural therapy adapted from treatment of alcohol and substance abuse therapy. The assumption was that pathological gambling resembled such addictions and that there would be similarities in treatment.

"There was something in common with drug treatment in the sense that it is about moderating behaviour, but there are some special things about gambling problems."
- Fekjær

Both Fekjær and Hansen admit that it was a test phase and project. They used techniques known from other addiction treatment, read international literature, cooperated with Renåvangen and Danish institutions focusing on gambling and improvised a lot.

"We said quite clearly that: We are now those under training, we don´t know much about this, but we are going to develop this service and we know a lot about treatment and such, but we don't know much about gambling (…)[T]hey understood that this was a whole new service and that "my information and what I tell is important""
- Hansen on how they explained the service to the users

As they started the treatment service, they did not really know what to expect, but the results were both shocking and incredible:

"It took off, we got a tremendous [number of] applications. Once we had completed the first couple of groups and the service had been known, we had such a big pressure on gambling, so pretty fast we had to split us in two and run each of our own groups, and we had groups continuously every week and it was pressure and we had to start up new ones. It was an enormous amount of work"
- Hansen on the start-up.

The treatment continued on and along with it came interest from the media and the professional community wanting to learn from the work at BKS. Fekjær, with the help of Hansen, held lectures, attended seminars and had visits from different actors observing their work. The flow of patients was continuous and the treatment seemed to work very well:

"They responded well to the treatment, much better than drug addicts. (…)It gave gratification, they [the gamblers] were more than 100% on team with us." *- Fekjær*

"It just kept on running by itself almost. It was so obvious that there was so horrendously many needy people and families whom needed help." *- Fekjær*

On from this point the story is remembered as a success. The treatment of gambling in general and the problem of gambling in Norway was increasingly picked up by the media and went on to become an important part of the political debate at the time, which accumulated in a gambling reform in 2003 banning privately run slot machines in Norway.

In retrospect, Fekjær is remembered as one of, if not "the", entrepreneur of gambling treatment in Norway, and at the start of this research it also looked as if this research would be represented as an entrepreneurial story. This is due not only to Fekjær´s involvement in the establishment of the gambling treatment at BKS, but perhaps more in connection with his following actions and political work. After starting up with the service, the intense push of patients and seemingly good results became a re-energizing for the veteran from the field of alcohol- and drug addiction, "an Indian summer" as he puts it himself. He became politically involved in the issue of gambling in Norway and participated by writing articles in newspapers and attending debates on TV and radio. Academically he wrote the "handbook" on gambling problems in Norway, which still is used in the curriculum of gambling treatment courses today, and also found among the references of this thesis. He and others also went on to establish *Norwegian Association for Gambling Issues* and he was for many years the association´s leader.

"He is one who turns personal and professional commitment into politics (…) that was very good in in this case."

- Hansen on Fekjær´s political participation

Fekjær in many ways became one of the leading people both academically and politically when it came to the field of gambling problems in Norway. A quick media search on *Fekjær* and *gambling addiction*, gives a result of 110 hits in national printed newspapers alone[4]. With experiences and later research from gambling treatment, he was amongst those initiating the

[4] Search performed with Atekst, Retriever, www.retriever-info.com. Search term: Fekjær spilleavhengighet*. Period: 1.1.1990-1.1.2015.

debate on gambling in Norway, and this is probably why he to this day has such a well-known position in the field.

Gambling treatment in Norway today

This paper seeks to find out how Blå Kors ended up introducing this treatment program and what were the major factors for this success. Today, Blå Kors still offer treatment for gambling problems at five of their institutions, it has also become known as Blå Kors´s specialization in the field of treatment work in Norway. As an example, Blå Kors Senter in Oslo "competes" with three other addiction treatment clinics, they all have the same basic field of operation, but all four have some sort of specialization in different directions, being it pill addiction or as in Blå Kors Senter´s case, gambling, differentiating them all a bit from each other.

The Norwegian Directorate of Health states that the emphasis of gambling treatment today is mainly within outpatient services from the field of interdisciplinary specialized substance abuse treatment, and cognitive behavioural therapy will be the recommended form of therapy in the official guidelines for treatment and rehabilitation of substance abuse and addiction by the directorate (IS-2219, expected completed 2015). (Correspondence with the Norwegian Directorate of Health 7.9.2015)

The treatment at BKS today and Norway in general resembles a lot of what was done by Fekjær and Hansen, it is still an outpatient service and with focus on cognitive behavioural treatment. The major changes today is the gambling market, which after the removal of the slot machines has been heavily influenced by the internet with online casinos and many other possible arenas for betting. New considerations are also other forms of "money spending" addictions, were it is not necessarily betting, but addictive online games that include the possibility of spending money to reach certain goals in a shorter time causing similar problems.

The treatment at BKS and Fekjær's work seems to have left its mark on the gambling treatment today. But this exact entrepreneurial story would not have been possible if it wasn´t for incidents leading up to Fekjær´s arrival at BKS.

4.4.1 The situation at Blå Kors Senter.

In the 1990´s Kristoffer Persson became responsible for representing the municipal of Oslo and "rusomsorgen" in negotiations and cooperation with external service providers.
He sat down and started comparing numbers and contracts to check if those providing the services fulfilled the agreed upon contract demands, and he found a displeasing pattern. Several service providers in the city did not actually provide the correct number of treatments or services that the contracts at the time demanded. Today he assumes the mismatch between what the public sector paid for in external services and the amount of services actually provided by 22 different external providers could have totalled to a value of 25 million NOK at the time.

" […] 25 million, thrown right out of the window when the public [sector] paid for something they didn´t receive." *– Persson*

Blå Kors Senter was one of these providers. The payment received from the public sector was for thirty treatment posts, but Blå Kors Senter had only produced twenty, and this had been going on for several years. Persson contacted Blå Kors and made them aware of the situation, something had to be done, or there would be consequences. Blå Kors responded by establishing a group to handle the situation, a positive and quick response not expected by Persson:

"I was impressed by the way Blå Kors handled this, they took it very seriously. (…) They were skilled, they took it very seriously, and they were meticulous"
– Persson

To respond to the situation a new director was brought into take charge of Blå Kors Senter. When Halvor Kjølstad came in charge of Blå Kors Senter in 1997, he remembers that the centre was not at its best. The running of the place had gone in a wrong direction, and bankruptcy and a shutdown was closing in on it, something needed to be done.

"The starting point was that this was about to crash and burn. […] Yes, we had the knife at our throat. I was very aware of this when I started there. And that was some of the fun too. There was talk about, not revolutionizing, but to develop something."
- Kjølstad

What exactly had gone wrong before the start of the reorganisation has not become clear during this research, but as an example; Persson remembers looking through some Blå Kors Senter budgets and finding expenses for five different janitors. The main focus of the reorganisation became to reduce costs and an increase of the professional level at the centre.

Both Kjølstad and Persson remember that one of the first priorities was to change how Blå Kors Senter operated. The operation had to shift from an inpatient service with patients receiving treatment over a long time, staying at the clinic, to a policlinic outpatient service. This was something the centre had wanted for many years and had applied funding for, but they had only received funding for inpatient services, making it impossible economically to shift their operations. This was now possible due to the pressing situation and the public sector, represented by Persson, wanting a fast solution. Both parties found the solution to be a much better alternative to the former operations. With Blå Kors Senter situated in the capital of Norway with all of their patients being residents of the city and living in close vicinity, inpatient treatment seemed unnecessary and it was accepted that there was not a great need for such services. The main treatment could still be offered within opening hours and most patients could then return to their own households. Blå Kors Senter also saw that availability of the service would increase. With an outpatient alternative they could reach people in need who perhaps did not have the time available to commit themselves to a longer treatment plan.

"Why should people stay the night at an institution if one does not need that? That's nonsense. Some clients who had good enough home conditions could then sleep at home and receive an outpatient service in the daytime, a slightly more flexible service."

The outpatient shift was important to reduce unnecessary costs and also hopefully reach new clients. But this was not the only development that was set into action to modernize and improve the centre. Kjølstad remembers that the employees at the time were a motley crowd and in dire need of new specialists to increase the professional level and hopefully improve the services.

One of the new specialists that were hired was one of the psychologists attending the conference in 1996, Hans Olav Fekjær. For Kjølstad he was a great addition to the modernized and reorganized Blå Kors Senter. Fekjær was well-known form the field of alcohol and drug treatment in Norway, and the two already knew each other. As to who

called whom first, they do not remember exactly, but both found it to be a positive and logical partnership to enter.

"[…] And Blå Kors had gotten a boss whom I knew well and appreciated, so it was natural to move across the street [from former workplace] […]"

- Fekjær

With Fekjær joining Blå Kors Senter in 1998, he also brought with him his new interest for gambling problems, which Kjølstad remembers as an additional bonus. The subject of gambling treatment had already been mentioned as a potential future service, but with Fekjær and his interest for the subject there was someone to initiate something. A new form of treatment service coincided well with the on-going wish at Blå Kors Senter to diversify their field and reaching new clients. The institution was still going through its modernization and reorganizational phase, so funding was an issue, there was little chance of receiving increased funding from the municipal government that they were still indebted to. But after some time Blå Kors Senter instead applied for a project grant commissioned by the State. The type of grant was at the time intended to fund new projects with the hope that they would be successful enough for the municipal government to take over the funding later on. The grant was approved.

The idea of a new service was presented for the municipal government, and was agreed upon. Blå Kors Senter got good feedback from their collaborators in the public sector, but with the instruction that the new possible service should not compromise the already on-going drug and alcohol treatment. Persson also remembers the discussion as quick and positive. The newly increased level of professionals and the handling of the whole reorganisation had impressed him. So when Blå Kors Senter came with their proposal, backed up by Fekjær, who Persson knew to be a renowned psychologist from the field of addiction treatment. From his perspective the need for gambling treatment would inevitably also be necessary in Oslo, since the only other provider of such treatment he knew of at the time was Renåvangen (more than 200 km from Oslo). Blå Kors Senter presented the idea and the possible close relation between the on-going addiction treatment and possible gambling treatment. That the project was all ready to be funded by the state, sealed the deal:

"Here we could conclude a deal, which was suitable for all parties, partly we got an adequate service for gambling addicts, partly we got something back for those millions

that we had paid that we would otherwise not get anything for, and partly we could develop a new service for the population of Oslo without costing the municipal of Oslo (local government) a penny, the money was there anyway." *- Persson*

It is here worth mentioning that is was also tried to introduce gambling treatment at Lade Behandlingssenter (treatment centre), a Blå Kors sibling clinic of BKS, but there the local government were not positive, fearing that it would negatively affect the on-going drug- and alcohol treatment. Jan Elverum, who was director there at the time, knew that the service was needed and could also see what went on at BKS, but the situation that Lade Behandlingssenter was in made it impossible. They chose to wait with it and in the meantime preparing a finished project plan for the day the possibility reappeared.

As mentioned earlier it was decided at BKS to make the project into an outpatient alternative opposed to Renåvangen who had an inpatient service:

"Basically we thought that employable cab drivers who were gambling addicts, there was no reason for them to lie in beds." *- Kjølstad*

Blå Kors Senter went on and used the grant funding to hire a new psychologist to collaborate with Fekjær on the project; "*We got a young and clever psychologist*" – *Fekjær.* And this psychologist was the newly educated Marianne Hansen. Together they started working on the project, and in the spring of 2000 Blå Kors Senter started up the first outpatient gambling treatment in Norway.

"We found it exciting too when we then began to go out and announce the service, that just the fact that it was an outpatient meant that people came who could come relatively anonymously and did not need to cancel their daily deeds even though they attended treatment" *- Kjølstad*

4.4.2 The organisation

Blå Kors, the organisation itself, was also going through changes at the time. In 1998 Geir Gundersen was elected the new general secretary of Blå Kors in Norway. The time he was in office has been known as a time of change for Blå Kors, with value- and operational changes. In a paper written on these changes in Blå Kors, Geir Gundersen is highlighted as a very important cause for the changes by the paper´s informants: "He was the right man, at the right

place, at the right time" (Ekroll, Grevstad, & Johnsen Solberg, 2009, p. 11). Gundersen himself adjusts this view somewhat, he agrees that he may have been a catalyst for some of the changes, but the changes would have occurred anyway he says, they just needed a practical outlet. Tendencies towards change had been going on for a long time in the organisation and discussions on strategic change were common. Most of the discussion on changes surrounded the values of the organisation. By reorganising, Blå Kors wanted to tighten the organisation and become a more apparent actor in the field of addiction treatment. All in all, it became a problem of reputation for the organisation. There were reports of Blå Kors institutions not using "Blå Kors" as part of their brand name, fearing connotations. Friction between volunteers and professionals caused by disagreements on the importance of Christian values had also been a problem, and one wanted to close this gap. The organisation needed to rebrand itself. Under the internal slogan *forenkling, forandring, foranking* (simplification, change and anchoring) the process of change went on in Blå Kors. At the general assembly of Blå Kors in 1999 and 2002, organisational changes were made and it was agreed upon values which both volunteers and professionals could stand behind (Ekroll et al., 2009, p. 6).

In the wake of this came also the wish for new challenges and to broaden the spectrum of the organisation, they had to think of something new and wanted an expansion in the already on-going addiction field. The new project by Blå Kors Senter was therefore something that aroused the interest of the organisation. It was a concept that was identifiable with addiction problems and could easily align within the organisations values and ideology. Gundersen remembers the gambling treatment as one of the things that eased all the internal changes; it was a "physical" evidence of change and something everybody could stand behind:

"It helped us out of the backwater of alcohol" - Gundersen

4.4.3 How BKS perceived Blå Kors.

The idea of this paper was partly to view how a voluntary organisation developed an innovation. Seeking to understand how the organisation played a role a long the way was therefore one of my main questions while conducting interviews. What some of my informants told me was that the organisation Blå Kors did not really have any involvement in

the process. To understand this, it is perhaps time to discuss the organisational situation in Blå Kors Norge.

Blå Kors Norge is organized on different levels with the general assembly as its highest authoritiy. Further down the line it is split into regions and divisions, in the treatment division we find the different institutions and clinics offering treatment. They are owned by Blå Kors Norge, but operate locally on behalf of their designated local health authority (Blå Kors Norge, 2014a). The image left behind after conducting this research resembles an organisational form of a franchise. Similar, but different institutions are connected through ownership and field of operation, but operate separately with strong connections to their own contracting entity in the public sector. The Blå Kors ownership appears to be an umbrella like connection, providing affiliation and cooperation through leader groups and working for and under the same organisational principals and goals. Except for formal relations, the operations at the institutions seem to go on as they please within the framework of the treatment field.

"I did not really have any daily relationship to Blå Kors. That I can´t say. It was natural for me as leader of a relatively big Blå Kors business to participate in and attend when it was general assembly, and also when it was bigger assessment work and such"

- Kjølstad

This resulted in an environment of much freedom to conduct operations as one wanted at the different institutions. Working at BKS is remembered as a place open for new ideas, not rigid, with academic freedom. Some of this is credited to the forces of change in the organisation itself. By modernizing the organisation and re-discussing old values, the rebranding mentioned before, it opened for a more diversified work environment capable of delivering modernized and professional service.

"Going to Blå Kors (BKS), then you would have fallen far! We struggled a bit with such a reputation, but it seemed to disappear a bit, because people realized that this was a proper service"

– Hansen on the old reputation of BKS

As to the development of gambling treatment, the BKS informants remember only positive feedback from the Blå Kors organisation, although not very much interest before it became apparent what impact the new treatment had.

"No, that was not necessary in Blå Kors. Because Blå Kors got more PR on this than they ever had had, so there [in Blå Kors], it was very popular."
- Fekjær on whether or not he needed to defend the project to Blå Kors.

"They were happy for, proud of and rooted for the project" - Hansen

5 Analysis

To present my findings and analysis, this chapter will heavily rely on the neo-Schumpeterian model introduced in chapter 3. The focus will be to connect the story told to the different aspects of the model. The hope is to shed light on the major events and key interactions leading up to the establishment of the gambling treatment. The model also shows separate actors and their connection to the service.

5.1 Analysing the case of gambling treatment

5.1.1 Service provider

The service provider in this case has been Blå Kors Senter (BKS) subject to the voluntary organisation Blå Kors Norge (Blå Kors). The connection between the service provider and the development of a service should be possible to explain by looking at the *service provider preferences* and possible changes in connection to the two underlying competences.

Trouble at BKS seems to have been the initiating force to changes at the clinic. After the problems were brought to the attention of Blå Kors they initiated two key processes. Kjølstad, who became the new director at BKS, focused on changing the way the clinic operated and to increase the professional level through staff replacements. The service operation shifted from a non-sustainable in-patient operation to an outpatient service. The changes in operation align well with examples of changes in *back office competence.* Economically it was an important shift to reduce costs; it was also made possible with the logistical opportunities brought on by the clinics placement in a greater city, in close vicinity of possible clients and their households. As to the new staff policy of attracting and hiring more professionals leads to an increase in *User facing competence* with an increased level in competence at the service provider. A perhaps unforeseeable hiring opportunity of Fekjær opened up as a consequence of this process of professionalizing, who later became important in the service establishment.

The hiring of Fekjær becomes important because of his already eager interest in pathological gambling, being one of two Norwegians at the conference in 1996. The other attendant had already at this time started up treatment at Renåvangen, and now the time came for Fekjær:

"[I] was a bit slower on the trigger, but then when I was at Blå Kors from 98…"

Combined with the organisational changes and the wish for expansion in new fields, the entrance of Fekjær timed well with the rest. Fekjær and his "bonus"-interest in gambling opened specific competence towards the field of gambling treatment. This opening probably was of great influence on the *service provider preference* to go ahead, enabling new possibilities at an already prepared service provider.

BKS is also remembered as a place with a large degree of professional freedom and openness towards new ideas. Based on Sørensen et al. (2013) this makes up for some of the organisational conditions necessary to achieve *bottom-up processes.*

Before going on to the other pieces in this puzzle, the connection to Blå Kors must also be considered. In the "back" of the back office is also what went on in Blå Kors, the organisation, were also things happened. The same wish to expand their work into new territory was on the agenda, together with solving an internal issue that had been going on for a while. Improving the environment in the organisation was done by opening up a discussion on values to decrease internal frictions between the increasing number of professionals and the established group of volunteers. This coincides well with what was going on at BKS, with an increase of new professionals and possibilities for a new service. Based on my informants at BKS, two of them do not consider Blå Kors or what was going on there as very important for what went on at the clinic. Timing would also indicate that changes had already happened at BKS before the events in the organisation. But Hansen on the other hand remembers discussions and openness on the value subject in her time, and that this had a unifying effect on staff also at BKS. The importance of these organisational changes at Blå Kors for the service development may be unclear, but with openness towards change in both camps, it at least seems to have decreased chances of possible confrontation between BKS and Blå Kors in the innovation process. It is also meaningful to point out that Blå Kors were the ones who had to take a stand on what to do with the problems at BKS when they were alerted to the lacking results towards the public sector, and chose to do something like hiring Kjølstad.

5.1.2 Policy maker

"The preferences of service providers and political policy makers may, and often do, clash."(Windrum & García-Goñi, 2008)

Filling the place of the policy maker in the model is Persson as the public sector representative. He may not have been involved in the development of policies controlling the public sector at the time, but in this case he is the one representing the public sector. He had the power and influence surrounding decisions important for the development of a new service and made decisions within the policy framework of the time. Public sector relations may be decisive for a service provider because of restrictions or advantages provided by the public policy. In this case it is also important to remember that although Blå Kors owned BKS in principle BKS were answering to the public sector as their contracting entity, which underlines the influence of this relation.

Looking at interactions, in this case, between service provider and the public sector it started out with preceding problems at BKS. Persson sounded the alarm on behalf of the public sector, when finding out that the terms agreed upon were not delivered by BKS. For him, representing the municipal government, there were two possible outcomes; Blå Kors fixed the problems at BKS or the contract was terminated. As told in chapter 4, Persson was satisfied and impressed by the quick response to the problem by Blå Kors. Not having to terminate the contract and having to find a new service provider, was a good solution for both parties. From this point on the interactions and relationship between BKS and the public sector is remembered, by Kjølstad and Person, as good and rewarding.

When it comes to the competence of the policy maker in this case, it does not seem to have been any clear change. Persson knew the addiction treatment sector in Oslo well, and also saw the clear advantages of changing the operations at BKS to an outpatient service. But when it comes to the introduction of gambling treatment, it seems that the interaction and discussion with Kjølstad and BKS were important. BKS presented the idea and showed how it related to already on-going addiction treatment and that it would benefit the public sector as well. Persson knew of the problems with gambling and had also heard about what was going on at Renåvangen. How much of an increase what BKS told him had on competence we do

not know, but it had a positive effect on preferences towards establishing a service. With a known problem and a service provider ready with a possible fix including a well-known psychologist leading the project, the prospect must have been appealing. The fact that the service was already paid for made the decision even easier for Persson. It was a rational decision, on behalf of the public sector, green-lighting a service that was needed and for free.

But this was on the local level of the public sector. The grant that initiated the possibilities for starting the treatment service came from the state level. Both Kjølstad and Fekjær admit that it would have been very difficult to start up any service without that grant. A possibility of funding from the local government was unlikely due to the situation of already "repaying" for former failure at BKS. The aim of the grant was to fill this lack of local funding to finance new initiatives, and so it fitted well with the situation and seems to have achieved its purpose, as we must assume was intended by the policy makers at the time.

5.1.3 Service users

In the Windrum and García-Goñi paper, the original model contains *user preferences* and *user competences* as the third influence on a service. What the user wants may contradict what the user needs, and so users have an impact on the success of a service by using or not using it.

When it comes to service users in this research, there is not collected any direct data that gives a picture of preferences and competence of users at the time. But during all interviews with all informants, the problem of increased gambling in Norway was highlighted by all as one of the main reasons for the development of a treatment service. The gambling liberalization mentioned in chapter 4 brought with it an increase in gamblers and thereby the number of pathological gamblers. The problem was escalating and visible for all. The increase in possible service users was not avoidable; the actual need for a treatment service seems to be the main influence from the user side of the model. When asked if the service would have been developed somewhere else if BKS had not developed it, those involved are curtain it would, it was necessary. The immediate rush of users as soon as the service was established also suggests that there was a considerable demand at the time.

The decision to develop an outpatient service was made to reach more users and also perhaps outweigh the problems of shame by providing a service easier combined and concealed with daily habits. If these were actual preferences of possible users, we will not know through this research. The assumptions of what the *user preferences* were did still, without the users involvement, affect the *service characteristics* in this case, which one may understand as a risk taken by the service provider at the time not able to predict a certain outcome of this choice. But several of the informants confirm today that shame is as problem connected to pathological gambling verified through personal experiences and research in the field.

5.2 Discussion

To finalize the analysis I will discuss the findings in relation to the literature and the influence of different effects in the development of gambling treatment. The discussion will try comment on what lessons that can be learned from this case.

The aim of this research was to investigate a case of innovation in the Norwegian voluntary sector by answering:

- How did treatment of pathological gambling develop in Norway?
- How did the resulting treatment service end up at Blå Kors Senter?

As the case unravelled itself, the range of subjects increased in many different directions, and the research offers insight into more fields than expected. To really learn something from this research, it is valuable to toughen the discussion and perhaps try to outline potential implications at a more general level.

This case shows how a long set of events and different social interactions lead up to the implementation of the gambling treatment at BKS. Literature on service innovation focuses on the service characteristics and how preferences among actors can explain the final service(Gallouj & Weinstein, 1997), this has further been adapted to include different competences at the service provider and other actors(Windrum & García-Goñi, 2008). Especially the organisational conditions at the service provider is used to explain how innovations develop(Sørensen et al., 2013). In this case, dynamics between the service provider and the public sector has initiated changes in operation at the service

provider. Managerial choices were then made to improve the situation at BKS. By changing the treatment operation to an outpatient alternative, the effectiveness of the clinic increased. Another step was to increase the professional level amongst the group of employees and volunteers, where the latter was partly phased and at the same new specialists were hired. These changes in *back office competence* and *user facing competence* at the service provider made BKS more capable to provide services than before. Included in the process of bringing in new specialist was also the hiring of Fekjær, a well renowned psychologist from the field of addiction treatment. Fekjær was also interested in gambling treatment, and together with Hansen, he later went on to develop a treatment service for gambling at BKS.

But for the development of the gambling treatment to take place, the case shows a number of situations that lead up to it. A lot of this would not have been possible without the right circumstances. Had there not been a problem at all, or more likely had the problem not been so severe, then perhaps the two psychologists at the conference in Amsterdam would just have returned home with some new ideas, easily forgotten if there was no need for such in Norway. Taking this strand of thoughts further brings us to all that went on at BKS before Fekjær's arrival. BKS could have avoided the problems in the first place, or Blå Kors could have chosen not to do anything about them. Although they did, the following changes applied did not necessarily have to be those that Kjølstad applied, even Kjølstad himself and his personal connection to Fekjær became important. The public grant, Person, Hansen and what happened at Blå Kors, all of it came together in one certain way before it was actually possible for the gambling treatment to develop. This is perhaps a very simple way of taking the process apart, but it is valuable to see that even if entrepreneurs can have a great impact on the success of innovations, they may sometimes be just the last piece in a great puzzle of social interactions.

But what is actually most important in the innovative process, the build-up or the final implementation? Among informants included in this research are those who believe that the development of gambling treatment in Norway would have happened at some point anyway, with or without this set of events and actors. I believe this to be a too simple view. Not only does it seem, as the situation at BKS was particularly well suited

for the development of a new service, but it also combined very well with the entrance of Fekjær. The actual development of the service was not possible without the entrepreneur to initiate the final steps of the process. Could anyone else than Fekjær in his situation have been this entrepreneur? Perhaps, but not just anyone. Fekjær's position in the addiction treatment field both academically and socially, combined with his personal interest for this new problem and his ability to reapply this to politics as well, all of this made Fekjær especially capable of taking the advantage in this situation. Others would perhaps not have been able to do this in such a fashion that it would end up with the introduction of a successful treatment service in Norway. This is why I believe it is absolutely fair to credit him for contributing to the success in this case. Having a great puzzle fitting perfectly together does not make for a complete puzzle without the last piece, and that piece needs to fit.

There is an ongoing debate in the literature on the importance and role of technology in Service innovation. The "reverse product cycle" of Barras (1986) has been criticised for the focus on technology. Although the theory is interesting when one wants to understand the implementation of technology into services, and how this through particular phases leads to new services, Gallouj (1998) and others argue that it cannot be seen as a theory of service innovation. The argument is that it does not encompass the variety in service innovation especially in fields less dependent on technology in their services. With the ongoing debate it is interesting to see that in the literature on health service innovation, technology is difficult to avoid as an explanatory element. Although having been adapted to include competences and focusing on learning by doing (Morlacchi & Nelson, 2011), the literature explains mostly innovations that are the result of implementing technology in some way. Advancements in modern medicine must perhaps be to blame for the technological focus, but is technology important in all fields of medicine? This case has actually shown how service innovation is possible without technology, *also* in the health sector. The innovation did not rely on any technology for its success. The literature on service innovation is still young, but perhaps can similar cases provide new insight to service innovation in general, but especially health service innovation?

Another debate on innovation this case touches upon, is innovation in the voluntary sector. The whole concept of using the term of the voluntary sector is already debateable, since it includes a great variety of actors providing different services in all kinds of situations, fields and sectors. The voluntary, non-profit and third sector definition only distinguishes these actors from private and public actors making it a categorisation of ideological character (Osborne, 1998a). The literature on non-profit innovation focuses a lot on the institutional environment of such organisations, often on the public policies. This is of course an important element for the operation of such organisations. So from an ideological standpoint and for public policy it is perhaps beneficial to use the term voluntary sector. But is it valuable or even possible to research non-profit innovation as a concept on its own? In this case the voluntary organisation and the innovation has not been possible to understand without considering the actual situation of operation. To explain how the treatment ended up at BKS and under Blå Kors, it is better to ask the question the other way around, how did Blå Kors end up where the treatment was developed? The organisation's ideological mission was to help out with problems in society caused by drug and alcohol abuse. This again manifested itself partly through treatment of addiction. This treatment service must be understood as a health service and part of the public health sector since the services were delivered on behalf of the public. It was not the nature of the organisation that created innovation, the innovation occurred within provision of health services and the voluntary organisation happened to be in the field of health services. Whether or not they want to, voluntary organisations will always be understood by their institutional environment and field of operation. This means that in the case of innovation research there will always be some category or sector more accurate to explain the situation and environment under which the researched innovation is developed. The voluntary aspect becomes secondary for innovation research, and to understand innovation in a voluntary organisation, it would perhaps be more valuable to decrease the importance of the voluntary element.

The non-profit aspect of such organisations is however interesting when discussing the value of innovation. In the private sector it is easy to see the benefits of innovation because of the possibilities to increase profits, but in the public sector and presumably in the non-profit sector, profits are of less importance. Innovation can still be important

for such actors because of the potential of improving services and effectiveness (Grimm et al., 2013).This case supports the literature, proving the value innovation can have for a voluntary organisation. The processes of change and the development of a new service, did not only open up new possibilities for the organisation, but strengthened the organisations position in its field of concern and society.

As to the relationship between the public and third sector and the idea of co-production to promote innovation in society(Pestoff et al., 2006), this case does not provide any evidence of this as a necessity for innovation at a voluntary actor. The case studied shows a relationship not fitting within the definition of co-production, it is a typical case of "total outsourcing" that is based on service provision according to contractual agreements (Windrum, 2014). It was disruptions in this relationship that initiated a process of change at the service provider creating innovation. One could perhaps credit some of the success to the seemingly good relationship between the public sector actor and the service provider. But at the same time the whole process of change had the only aim of realigning to the same old type of relationship. Good or bad relations among such actors will not change the fact that there will always be a disproportion of dependence among them, and the voluntary sector is the one that has to adapt the most. Aiming for a state of co-production can be of ideological value, but such relations will never be perfectly smooth. One could also ask if co-production perhaps would lead to increased pressure on the voluntary actors. In a case of "total outsourcing", the service provider must only provide according to the contractual demands settled upon, with no involvement from the public sector as long as the demands are met. BKS was brought to the attention of the public sector because of the lack of results. But in a case of cooperation, the service provider would always be under attention, and the public sector would probably have a greater interest in and opinions on how the services are provided and perhaps intervene in different ways with the operations, combining this with the disproportions in power would lead to a difficult situation for the service provider.

Literature on the voluntary sector has shown a tendency towards professionalization of voluntary organisations due to changes in society and policy, which again has forced such organisations to be increasingly dependent on the public sector(Gulbrandsen &

Ødegård, 2011). It is also believed that the final result of this tightening relationship will lead to a situation of: "*Terminated cooperation or full integration with the public"(Lorentzen, 1994)* . But this case disagrees with the assumption that professionalism is a negative trend and that public sector relations leads to *full integration.* An organisation can in fact go through professionalization and continue the ideological mission to improve society, and at the same time keep its integrity while providing services on behalf of the public sector. But it is a tough process with quite considerable changes to the organisational build-up and perhaps a need to also adapt core values to fit within the new situation. This case has shown Blå Kors, a big and well-renown voluntary organisation going through a difficult time of internal difficulties and external pressure. The organisation went through a process of rebranding, adapting former values and organisational structures to accommodate a new era. Blå Kors came out of this as an organisation more capable of withstanding challenges and at the same time able to maintain their original mission and core values. This raises the question of professionalization, being viewed as negative for the voluntary sector by many. But, is it a problem or can it in fact be a solution? Making voluntary organisations better able to cope with new challenges, and maybe it is a necessary step in the evolution of such organisations?

The rickety relationship with the public sector and the attempts to fix it lead, as already mentioned, to the set of events important for this case. This shows that effects of public sector pressure on voluntary service providers can bring along necessary improvements and even innovation at such actors. This case does not support a possible idea of voluntary actors not able to handle difficulties, and this can perhaps be of comfort for Norwegian voluntary organisations concerned with the likely future of increased competition (Frivillighet Norge, 2014). As mentioned in the case of Blå Kors and BKS, the resulting improvements actually lead to an increase in service quality and not only did gambling treatment open new possibilities in the field of addiction treatment, but it also strengthened Blå Kors' position in the field.

5.3 Conclusion

Innovation has gained an increasingly important role in how we look at the future of organisations and the development in society. Policy makers have turned their attention to the concept of *social innovation* as a possible solution to future societal problems and challenges. It is not believed that the modern welfare state alone can provide all the necessary services demanded by society. The co-production strand of social innovation emphasises how the public sector in cooperation with other actors can create and explore new - and possibly better solutions. Voluntary organizations are believed to be actors that are suitable for such cooperation. If the voluntary sector has an increasingly important part in future society, research on such organisations can provide useful insights to better understand the sector at hand.

This qualitative case study was done with the intention of learning something new about specifically *innovation* in the voluntary sector. At the core of the research were the questions:

- How did treatment of pathological gambling develop in Norway?
- How did the resulting treatment service end up at Blå Kors Senter?

The research showed that what at first looked like an entrepreneurial story, is also the story of a set of events leading up to and forming the basis for the final implementation of the treatment service.

This paper has shown that when looking at innovation in connection with voluntary organisations there are some considerations to be made. It is perhaps better to look at the organisation with a focus on its field of operation and not its voluntary value. To explain how gambling treatment developed in Norway it was necessary to focus on Blå Kors Senter's role as a service provider in the health sector, using a model relevant to do so. This raises the question on whether or not it is valuable for this research to say something in general about innovation in the voluntary sector.

What the research can say something about is health service innovation. In the field of service innovation, the role of technology to explain service innovation has been a hot topic

of debate. In this case the health service innovation is not affected by technology, which is a rather rare case in service innovation literature, especially on health services. The case supports the notion that Barras' "reverse product cycle" is not applicable to view all forms of service innovation, and should not be used as a theory to understand all service innovation, but rather be supplementary.

The research has also shown the value of innovation for a voluntary organisation. The new treatment combined with the professionalization and rebranding of Blå Kors, strengthened the organisation in the field of addiction treatment and in society. As to public and voluntary sector relations, the research shows a case with tendencies of good relations, but with no cooperation suggesting *co-production.*

Unboxing this case has been a long process. The research was intended to learn something about innovation in the voluntary sector by looking at the development of gambling treatment in Norway. But the research did not only provide answers to that, the research also led to insights on different topics interesting for innovation research, and perhaps also for public policy makers and others.

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